

#28

PA-1RE 936

UNITED STATES GOVERNMENT

memorandum

DATE: August 9, 1979

REPLY TO  
ATTN OF: Elizabeth Jean Hunt, PPC/E/S *EF*

SUBJECT: Travel to Colombia: April 23 - May 8, 1979

TO: The Files

Part I: International Conference on Health Financing held at Melgar, Colombia, April 23-27, 1979.

Part II: Travel to Project Sites of the Colombia MOH Regionalized Low-Cost Health Delivery Program (MAC) in the vicinity of the Cartagena, Manizales and Villavicencio for observation with members of an observation team from the MOH of Bolivia.

Members of the Traveling Party were: Dr. Cuevar, National Director of Planning, MSW/PH; Elizabeth Hunt, Social Science Analyst, USAID; Julio Arano Saldana, National Director of Administration, MSW/PH; Dr. Glicerio Rojas, National Director of Health, MSW/PH; Dr. Carlos Tobon Niebles, Chief Advisor and Project Manager to USAID/Bolivia Montero Rural Health Project (formerly National Director of Community Participation and National Coordinator for the Plan for Rural Health, Colombian MOH).



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## PART II

### Some Field Observations from Visits to Sites of the Primary Health Program of Colombia

The field trip portion of the trip was a follow-on to the Health Financing Conference at Melgar, Colombia the week of April 23, 1979. The Bolivian delegation to the health conference had requested an opportunity to observe sites of the Colombian regionalized, primary health delivery system. Bolivia is just beginning to set up such a system, and Colombia is considered to be quite far advanced. The Bolivian request in and of itself might be viewed as a sign of Colombian success.

The trip was far richer in insights due to the presence of Dr. Carlos Tobon Niebles who currently manages the Montero project for USAID/Bolivia and who formerly was employed by the MOH of Colombia playing a major role in the design of the local level of the Colombian system. (He was at the time--1975--National Director for Community Participation and, either simultaneously or immediately following, National Coordinator for the Rural Health Plan.) Currently, he is regional monitor/manager (asessor) for AID's Montero Pilot Project and in that role (and presumably because of his past connections with the Colombian system), he was asked to "escort" the Bolivians.

Therefore the chance existed to compare the on-site realities with the original plan. More importantly, the questions Dr. Tobon chose to ask with 4-5 years intense personal investment and interest in the program and having been away from it for a year or more were extremely penetrating and elicited much revealing and useful information.

Immense contrasts presented themselves. The intense dedication of this doctor and the evident enthusiasm of the involved Colombians at all levels--promotoras, doctors, bureaucrats--made the disinterest of the Bolivian functionaries embarrassingly evident at times. The sample of course is small--but numerous issues of quality of management had to come to mind after a week of seeing the differences in attitude.

Dr. Tobon demonstrated an immense rapport with all levels of people, a great respect for all people and an impressive knowledge of the rural areas of Colombia and their people. This latter knowledge was gained mainly through years of service in some of Colombia's most difficult terrain directing anti-malaria campaigns. It would be next to impossible to quantify just what differences having a person like this design/direct a program meant for rural areas as opposed to having an entirely urban-based person do it makes; the differences, however, must be considerable.

### The System

First, it should be stated that, although there are any number of interesting independent or, separate but intertwined, programs and institutions operating in Colombia, this discussion is restricted wholly to the primary health delivery program of the Ministry of Health. Since there are tangential points, the P.A.N. (Plan for Food and Nutrition) and the Mother/Child programs are mentioned. However, they are not the primary emphasis.

The Colombian health system is first national, but then very much regionalized. The whole system was overhauled in the early 1970's with much emphasis on planning. In 1975, the first local units were designed and set up. These are known as the "MAC", or loosely translated, modules for expansion/amplification of coverage—a term which describes their intent and results in a handy acronym.

Attached appendices present a diagrammatic scheme of the way authority is delegated downward (Appendix A) and the way cases are referred upward (Appendix B) through the system. A third appendix (C) lists the documents brought back from Colombia which describe the system in considerable detail.

The following Colombian semantic anomaly deserves attention. In Colombia, a region is a subunit within a department, thus the term "regional" means intra-departmental rather than supra-departmental. The health system is thus national, then is implemented at the departmental or sectional level, and only thirdly at the regional level, followed finally by the local level which itself breaks down further into the communities.

### Sites Visited

It was decided that the group should visit sites in three areas of the country: Villavicencio capital of the Department of Meta on the edge of the llano, Cartagena capital of the Department of Bolivar on the Caribbean Coast, and Manizales capital of Caldas, a highland coffee Department. In the first two cases the sites visited were several hours' drive outside the department capital—and we would have visited sites even more remote had torrential rains not torn out a bridge and badly mauled the roads. In Manizales—mostly due to a late arrival—we saw only an urban health center directly attached to a university teaching hospital. That in itself, however, was instructive.

The particular three areas chosen were intended to illustrate "sectionals" in which the system was fully integrated, was just beginning to be integrated, and was at the intermediate state. This distinction

was not clear as might have been hoped, but it would have taken more time in each region to fully appreciate the differences. In the time allowed one did well to understand the general system let alone the local differences.

A pastiche of observations, comments, and—it is hoped—insights follows—organized by topical headings.

1. Community Participation

Community participation was most notable in the discussion at the Villavicencio regional sites and at San Juan Nepomucena in the Carmen del Bolivar/Cartagena region.

A. At Villavicencio (Castillo) it was flatly stated that:

"without community participation primary attention does not advance."

Unfortunately, I do not recall if this quote came from a promotora or a doctor. One way the promotoras in the Villavicencio area are reaching people is through the parents' meetings at the local school. When pressed, however, they admitted that they were only reaching some 10% of the community this way. In the absence of parents' meetings, they were giving talks to students. And in those cases where neither was practical they were giving talks on feast days at the community gathering.

The local hospital at Acacias was also used for teaching and public relations on holidays—there the staff was giving talks to groups of people periodically throughout such days on topics of basic hygiene and health.

B. San Juan Nepomucena

Not only the promotoras but also the community representatives to the Central committee elected by the barrios were present. There was a somewhat more "political" tone to the discussion as well as a somewhat more combative one—it might be interesting to pursue what the history of community participation in the various areas has been.

The program in this region was begun with assemblies of barrio residents who elected a representative to the Central Committee. There were 15 barrios represented. (Also four veredas—although the four veredas may have been counted as part of the 15.)

It was reported that originally some communities were highly suspicious of this process assuming that the committee was to deal with political problems. This was not unsensible as it was later suggested that at least two community participation organizations had been formed previously in

Colombia—one having gone to the right and one to the left. (See Appendix D.) The group at San Juan Nepomucena insisted that (at least there) the committee represented all colors of the political spectrum. The committee had elected a president, but that person exercised no political authority.

Asked if the people had "spontaneously" requested these services and established the institutions—(a rather disingenuous question, actually)—one of the committee members replied that:

"the necessity was latent in the community. A government representative helped the concerns (ansias-anxieties) to 'flower' and encouraged us (nos animó) to do the campaigns."

The general tone of the meeting suggested that the government had a following only when the people saw it very much in their favor to do so—(i.e., the general tone verged on the ascerbic—perhaps a reflection of the weighted nature of some of the questions, perhaps indicative of a jaundiced view of central government).

The committee was clearly seen by both the members and the local hospital director to be functioning as a pressure group which "denounced problems" to the municipal authorities. Furthermore, it was clear that the hospital director and the director of the regional unit (Dr. Martinez) both saw this as a help to them rather than a threat. They explained that there was a hierarchy of decision making—that complaints (denuncios) went up a ladder—and that they felt much more "powerful" going to a higher authority knowing that they had the quite vociferous support of the community to "back" them.

## 2. Relationship of Community and Promotora

The promotoras are chosen by the communities and presented to the Health Service which trains them. At Villavicencio the promotoras were given scholarships which were paid off by service. However, if they moved away or resigned (upon marrying or for some other reason) they were required to pay back the "loan" in money. I did not discover how frequently a promotora resigns before her term of duty is up nor how frequently the money is actually recovered in such a case, but the topic was gone over so lightly it give the impression that the situation rarely arises.

## 3. Wallposters

In the hospitals and health centers, there were posters urging people to breastfeed their infants and to vaccinate their pets or household animals. (Basically to combat rabies.)

#### 4. Usage of Facilities

The Centro de Salud visited in Manizales (an urban centro) estimated it averages 1,000 plus consultancies each month. In Manizales, which is the departmental capital for Caldas and has a teaching hospital, much of the work was being done by 4th year medical students.

The clinic was not crowded, but there were about 10 patients in the clinic mid-afternoon on a Friday. Our visit had not been scheduled, so the number of patients was not changed by our visit. In the other visits a feeling for volume-of-use was more difficult since we were obviously expected and all the promotoras and/or the local committees had been gathered together. Furthermore, in Villavicencio we were there on a Sunday.

#### 5. Indigenous Health

If and how parteras and curanderos are used seems to be decided at the departmental or regional levels. However, there is some evidence that they are being used at least in some of the departments.

Sympathy with the use of curanderos in Indian areas was expressed by Dr. Gomez, Director of the Teaching University Hospital in Manizales. He also mentioned the parteras were incorporated into the system. The Director indicated some midwives were teaching at the hospital. I am unclear whether those teaching were indigenous practitioners or nurse-midwives.

Also in San Juan Nepomucena—it was mentioned that most of the empirical midwives or parteras had been brought in for training at which time they were given kits (maletas) which included scissors.

#### 6. Planning—Evaluation

Not only does planning and evaluation exist—it is apparently being regionalized—and apparently taken seriously. Dr. Martínez, Director of the Regional level for Carmen del Bolívar (Cartagena area) spoke specifically of being in the evaluation phase of the program. And as I recall this observation was totally unsolicited (I doubt highly he had any notion that I was from an evaluation office).

At the Ministry, I was told a full-scale national evaluation of the primary health care or M.A.C. system was underway. The documents are due out in September, 1979. Last year there was a mini-evaluation at another donor's behest. Only a few copies were made as it was "to please them". The current evaluation seems to be seen as a venture for Colombian use, however, and they plan to publish it. Contact: Magnolia Giraldo.

### 7. Payment for Services

At both Manizales and San Juan Nepomucena the cost of a consultation was 20 pesos or approximately 50 cents. Indigents are treated free at all levels of the system up through complicated surgery at the regional or university hospitals.

The auxiliaries are from the area and it is assumed they can distinguish who can and who cannot pay for services. This was in the urban center in Manizales. I assume this function might well devolve upon the promotoras in more rural areas with highly dispersed populations where auxiliaries would be less likely to know all the individual families well.

### 8. Funding of Health Services

At the sectional level lottery earnings are being used to help finance health services. In the Department of Caldas it was said that approximately 35 percent of earnings from the lottery go to health and that 20 percent of the health budget comes from the lottery.

A computer breakdown of financing at the national level was presented by the Colombians at the Conference.

### 9. Community Pharmacies

The suggested standard is that they charge 15-20 percent mark-up over the cost of drugs which is still much less than the going retail rate. The pharmacies in theory stock 100 basic drugs, most of which are manufactured in Colombia so there are not problems with importation delays. Payment for drugs is strongly encouraged although they will be given free in emergency ambulatory cases.

This appears to be one of the weaker points of the system.

The pharmacy visited was in an urban health center in a departmental capital—hardly the most difficult case. It looked well-stocked although I doubted there were 100 different drugs, but then with electricity and a teaching hospital within ten minutes drive there would be little enough reason for it not to be.

### 10. Use of Promotoras

In the 1975 Plan for the local level of the health delivery system, the promotoras are given an extraordinary range of duties including:

1. monitoring pregnancies,
2. delivering normal cases,

3. selecting and enrolling mothers in the nutritional Protection and Food Education Project,
4. home visits to new mothers and their infants,
5. information on family planning,
6. home visits to check for best use of foods and to encourage home gardens and small livestock projects,
7. attending children and adults with the following problems:
  - a. diarrhea and vomiting,
  - b. respiratory infections,
  - c. cough and fever,
  - d. dehydration,
  - e. intestinal parasites,
  - f. malnutrition,
  - g. "brotos" and fever,
  - h. anemia,
  - i. malaria, and
  - j. first aid (bites, burns, fractures, convulsions, poisoning and asfixiation),
8. taking samples of blood for malaria and sputum for tuberculosis,
9. preselecting children under five with symptoms of malnutrition and referring them to the Ambulatory Protection and Recuperation Nutrition Project,
10. visiting those children enrolled at home to monitor their progress, and
11. giving health and nutrition talks.

Presumably, they are dispersing simple medicines in order to do some of the above.

In fact it appears that only the promotoras serving on the farthest fringes are having anything near this number of duties allocated them. The promotoras I talked with were not handling medicines and there seemed to be a separate inoculator for vaccination campaigns. They were serving mostly as motivators, as conduits for community opinion and as scouts for problems which they referred to the health center or the local hospital.

One aspect of the Colombian system is that the promotoras can be attached at a long chain of command or almost directly to a sectional hospital depending on whether they are serving in a remote rural area or in a marginal urban zone. It, therefore, follows that there would be some differences in their duties.

In the Villavicencio sectional the promotoras working out of the local hospital at Guayama said they used no medicines but promotoras working further out from the state capital in fact did administer certain medicines. Again at Villavicencio I was told that volunteers had been used for some 20 years but in a very disorganized manner.

Auxiliaries (or promotoras) were once volunteers but as of four years ago they were contracted for a full day's work and paid the minimum wage for the area in which they were working. This has allowed much stricter supervision—as one Doctor observed, it was rather difficult to push someone to work harder who was doing it strictly by their own good graces. A salary means status for the worker and leverage for the supervisor.

11. Training

Promotor de Ambiente:

Trained in Bogota, Medellín and Palmear in el Valle.  
4 months theory, 1 month practice

Auxiliary Nurse:

Used to require two years high school; now requires four years as a prerequisite. Eighteen months training—12 of theory, 6 practical. Dr. Tobon appears to think this may be a bit excessive.

Promotora:

Three months initial training followed by a meeting once a month—partially for continuing training.

12. Dedication/Enthusiasm of Staff

The doctors directing vocational and regional programs and serving in local hospitals seemed genuinely enthusiastic and motivated. Most seemed highly sympathetic to para-professionals, parteras, community participation, and highly put off by the sophisticated specializations of the medical schools.

One promotora said specifically she was satisfied with her pay (minimum wage) and with her transportation (in this case a bicycle—in others a mule), but she wanted more training.

The promotor de ambiente (Sanitary Promotor) in Guayama--  
Acacias--Villavicencio--had taken the job because he did not get  
into medical school and had a year to fill!! But he had become so  
enthusiastic that he had decided to study civil engineering instead  
and continue with the work he was doing at a more professional level.

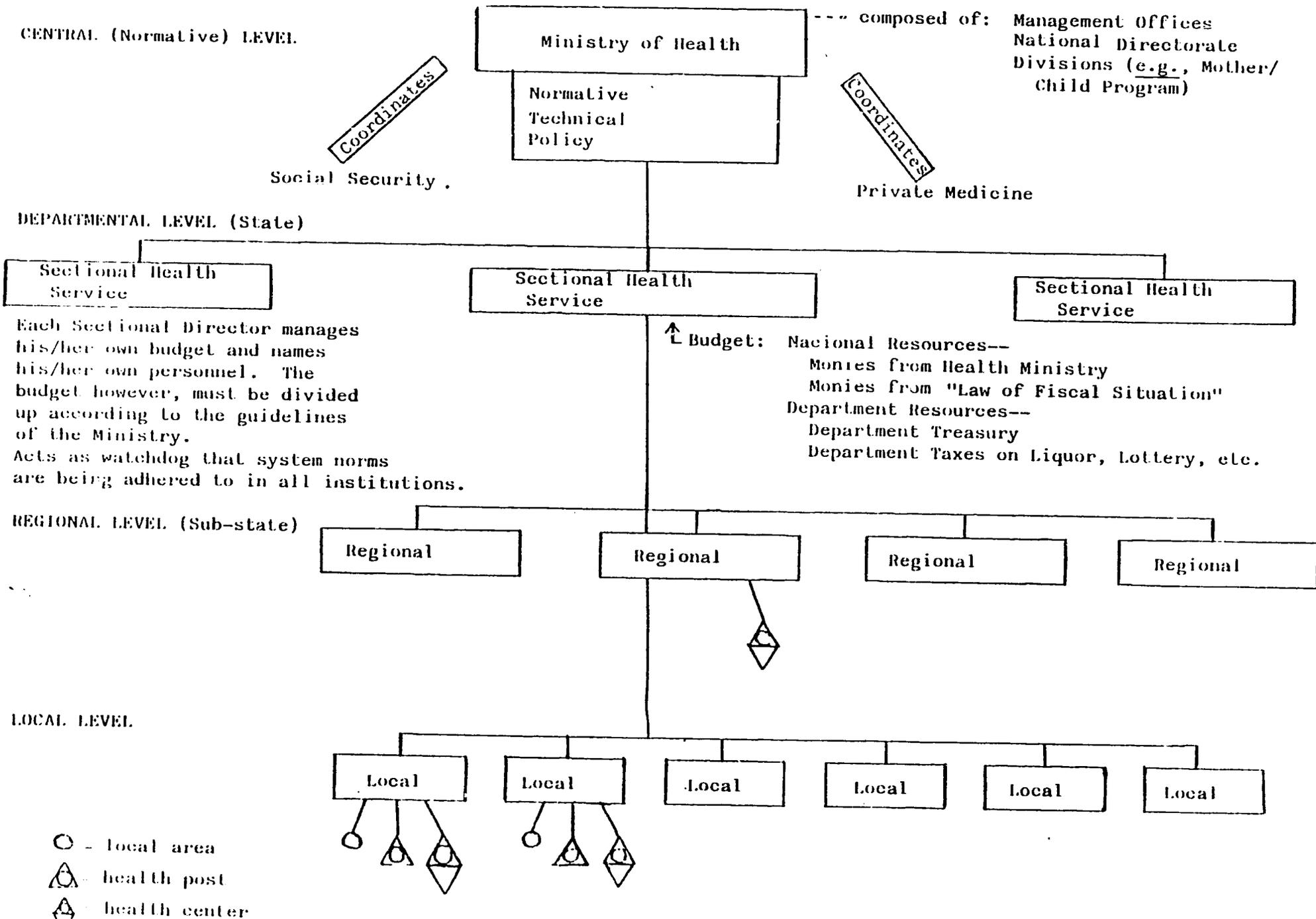
Teamwork--There were tales of a whole group of people working  
regularly 8:00 a.m. to 2:00 a.m. at the ministry while the system  
was being designed. Five years later there appeared to be considerable  
comaraderie remaining.

### 13. Suspected Problems

At the ministry it was said that it is suspected that money is  
accumulating at the local hospital level and not flowing on down to  
health centers, health posts, and the promotoras as smoothly as  
might be hoped. This is one of the questions for which the ministry  
hopes to gather evidence in its ongoing evaluation of the local level  
of the health system or of the M.A.C.

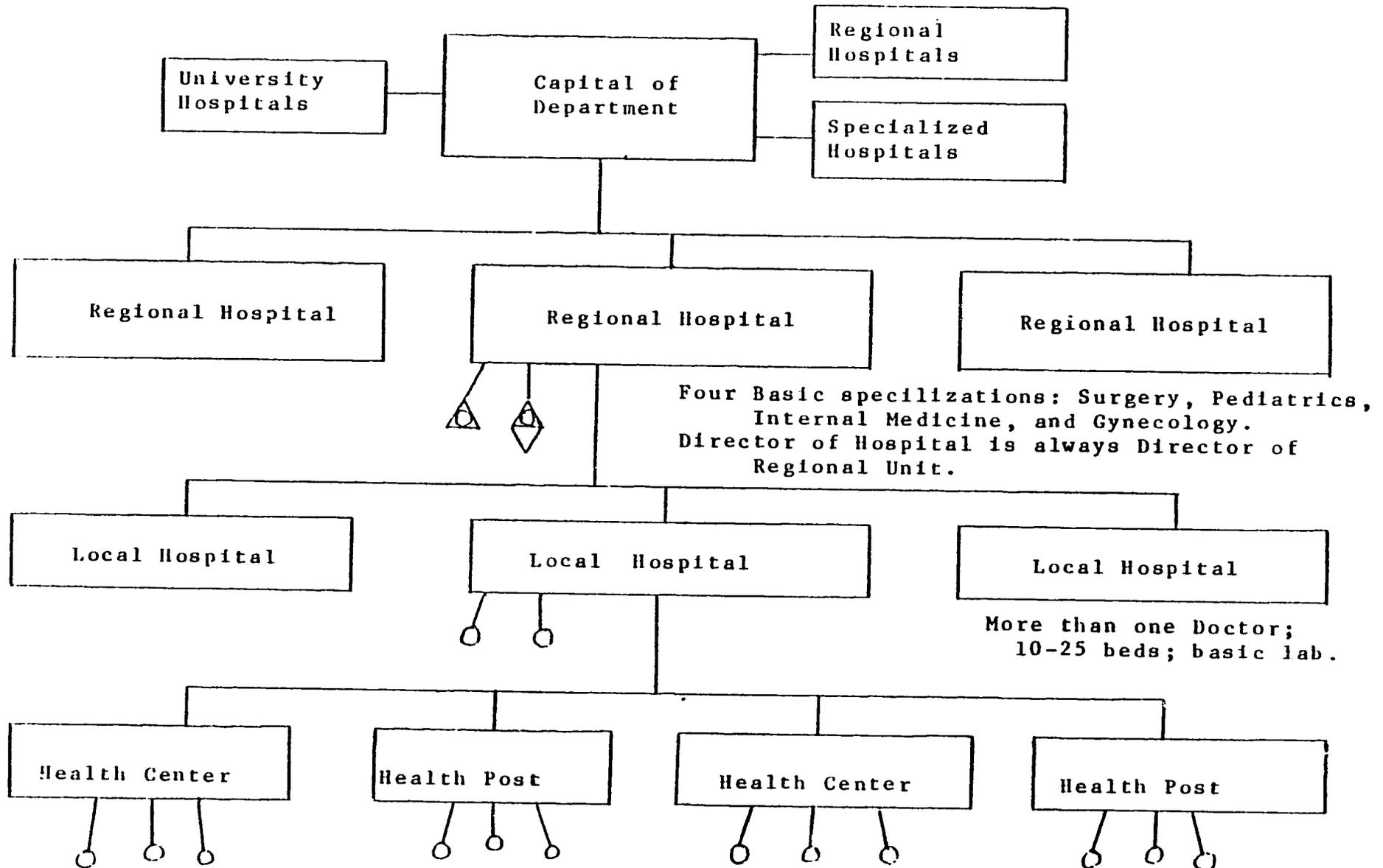
Although the Ministry staff working with low-cost health delivery  
system was extremely enthusiastic and dedicated, there was some  
indication that there was less high-level support than earlier and that  
budget allocations for this activity might be less than could be  
hoped.

APPENDIX A



REFERRAL SYSTEM FROM BASE (PROMOTORA) UP THROUGH THE  
TEACHING AND SPECIALIZED HOSPITALS IN DEPARTMENTAL CAPITALS

APPENDIX B



○ = coverage unit (1 promotora)

△ = health post (1 auxiliary)

◊ = health center (permanent doctor and auxiliary nurse)

APPENDIX C

\* List of Documents on the Colombian Health System brought Back to Washington

- 1975 Institutional Spending in Health. Planning Office, Ministry of Health
- 1975 National Health Plan: First Phase - Local Level  
ISNS Document #11, Ministry of Public Health
- 1978 Extension of Coverage of Health Services Based on Primary Attention. Bogota, Meeting of Chiefs of Sectional Services and the Ministry of Health and its Ascribed Institutions.
- 1978 Methodology for Implementation of the Planning Subsystem. Ministry of Health, 2 Volumes.
- 1979 Aspects of Financing and Spending in Health: Colombia 1974-1980. The Document prepared for the Health Financing Conference at Melgar.

\* All of these documents are in Spanish.

## APPENDIX D

Although the following quote comes from an article describing a series of agrarian reform/rural development activities in Colombia in the mid-1960's, this author believes it goes a long way in explaining the suspicion of community participation committees at the grass roots level. Note especially the first and the fifth (last) paragraphs.

Bureaucratic Control. Thirteen government agencies were involved in the DRI. Most of them would relate to the small farmer and his community through organizations called comites. Comites were formed at the lowest local levels of government, the veredas and municipios. Veredas were small, essentially family groupings, a number of which made up a municipio whose center was a village or town. The bureaucratic nature of the comite was symbolized by the fact that the secretary was the local representative of the Caja Agraria, the agency which had control over credit. The comite also consisted of representatives of ~~ICA~~ the national training institute, the Servicio Nacional de Aprendizaje (SENA), and all other government agencies operating in the area. Representatives of the farmers were also present. In Rionegro, I was told that the meetings normally consisted of reports by the bureaucrats on future activities of their respective agencies. Farmer participation was reported to be minimal, and I was told that many farmers no longer attended meetings.

In the planning states of DRI, a planning department evaluation team suggested that farmers be given a direct role in shaping the program. This was rejected in favor of a consultative role so that comites merely reviewed the yearly plans for the program.

Decisionmaking rested with the Presidency of the Republic and the international agencies. The national planning department presented plans and budgetary proposals to them through the National Council for Social and Economic Policy. The plans were worked out with the local, municipal, departmental and national officials of the twelve other agencies and reviewed by the comites. The director of the DRI division of the planning department had field directors in constant communication with the regional directors of the other agencies. They were in charge of coordinating the field activities of the local personnel.

Each cooperating agency had a specific role to play in the program. ICA was in charge of designing technology and, in the project areas I visited, continued to transmit it directly to farm families. SENA organized farmers for courses for courses in production, marketing training of all kinds. The Central de Cooperativas de la Reforma Agraria (CECORA) organized farmers for the purpose of marketing their produce. The Caja Agraria set credit guidelines. In order to receive credit the farmer had to design a so-called integrated farm plan with the help of ICA or the Instituto de los Recursos Naturales Renovables y del Medio Ambiente (INDERENA) or both. The other ministries were to provide social and economic infrastructure including roads, schools, teach training, health posts, electrification, etc.

Thus the DRI farmer was surrounded by technicians and advisors. In the case of most ministries, communication was through the comite, as we have seen. In the case of ICA, SENA, the Caja and CECORA, communication was direct. Each DRI family was in their special care; this was because each family was considered a potential leader in the community. For example, ICA was in the process of gathering minute details about each family's home life in order that DRI might design programs to improve it. The so-called ficha filled out by the home improvement staff contained such data as the amount of protein consumed weekly, the kind of clothes worn, family illness, hygiene, patterns of recreation, etc. The paternalistic thrust of the program was all-encompassing.

Galli, Rosemary; "Rural Development As Social Control: International Agencies and Class Struggle in the Colombian Countryside", Latin American Perspectives, Issue 19, Fall, 1978, Volume V, No. 4, Pp. 84 and 85.

